Department of Medical Assistance Services
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MEDICAID MEMO

TO: Medicaid Enrolled Providers of Respite Services and Services Facilitators through the Elderly or Disabled with Consumer Direction, Individual and Family Developmental Disabilities Support and Intellectual Disabilities Waivers

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 8/23/2013

SUBJECT: Respite Care Service Authorizations Extended to 8/31/13 — Provider Questions

The purpose of this memorandum is to notify Home and Community Based Waiver providers that the Department of Medical Assistance Services (DMAS) has received multiple questions from providers regarding the extended respite service authorizations. The extension of respite authorizations affected agency and consumer-directed respite authorizations in the Elderly or Disabled with Consumer Direction, Individual and Family Developmental Disabilities Support and Intellectual Disabilities Waivers and was addressed in a previous Medicaid Memorandum dated August 13, 2013.

Why Extensions Were Automatically Generated

On July 1, 2011, the regulatory limit for respite was decreased from 720 hours per calendar year (January through December) to 480 hours per fiscal year (July 1st through June 30th). In June 2011, DMAS end dated all respite authorizations that had 720 hours, with the end date June 30, 2011. To assist the providers who had their authorizations closed with the end date June 30, 2011 DMAS automatically generated a new authorization for 480 hours from July 1, 2011 – June 30, 2013. This information was communicated through the Medicaid Memo issued June 6, 2011. Providers and members received letters for these auto-generated authorization lines.

Many providers submitted respite requests prior to the expiration of the service authorization ending June 30, 2013. However, for those providers that did not, continuity of care was jeopardized for the member; DMAS directed the auto-generation of the extension from July 1, 2013 through August 31, 2013 in order for the member to continue to receive respite care thereby giving providers this 2-month window to gather needed documents and submit a request for respite for the full 12 month period. DMAS recognizes that the influx of respite requests has caused a back log in EDCD waiver processing at KePRO and we are working on resolving this issue.

What Should You Do

It is the provider's responsibility to track authorized periods for services, and to submit requests prior to the expiration of those authorizations if the member continues to need those services. If you have already submitted a request for respite, you do not need to do anything further. Your

request will be reviewed in the order it was received. If you have not already submitted a request for respite, you need to do so.

Questions Received from Providers

With the auto-generation of the authorized dates 7/1/13 – 8/31/13, and the requests submitted by providers for respite to KePRO and DBHDS, some providers now have 2 authorizations, which in most instances have overlapping dates. Following are questions received by providers and DMAS' response.

	Questions from Agency Directed Providers	DMAS Response
1	I have 2 service authorizations, one with dates of service 7/1/13 – 8/31/13 and the other one from 7/1/13 – 6/30/14. Which one should be used for submitting claims?	It is preferred that providers submit claims under the longer 12-month segment. If providers have already submitted claims under the short segment, begin using the long segment for the next billing cycle. Claims edits will prevent payment for same dates of service under both authorization numbers.
2	I did not get a letter from KePRO that showed auto-generated authorizations from 7/1/13 – 8/31/13. Should I expect a letter from KePRO?	Being that KePRO did not receive a request, nor initiate the generation of the authorization, providers will not receive notice letters from KePRO. The MMIS generated letter is the final determination and your authorization to bill.
3	My initial paperwork was sent to KePRO on 07/11/13 for a new admission. The 30 day visit is due this week. Should we do the 30 day visit now, or wait & do it when we receive an authorization?	This response applies to new admissions for both consumer and agency directed. Providers are to follow all the rules as outlined in the manuals to decrease potential penalty on post payment review.
4	Will DMAS perform post payment review on these respite authorizations from 7/1/13 – 8/31/13 that were auto-generated?	This response applies to both consumer and agency directed respite. Yes. DMAS will conduct post payment review to determine if respite criteria were met for the dates of services billed/paid.
	Questions from Consumer Directed Providers	**DMAS Response**
1	I have 2 service authorizations, one with dates of service 7/1/13 – 8/31/13 and the other one from 7/1/13 – 6/30/14. I can only see the short segment in the PPL web portal. Does this mean I need to resubmit my request to KePRO or DBHDS?	No. Please do not resubmit requests if you have already submitted one. DMAS has assured that PPL received the longer segment that spans 12 months. Providers should now be able to see the longer segment in PPL's web portal.
2	Can we bill for CD Management Training for the administrative time to develop documentation for the service authorization?	No. This is not permitted and will be retracted upon post payment review should you build time into your claim submission for preparing service authorization documentation.
3	Will DMAS perform post payment review on these respite authorizations from 7/1/13 – 8/31/13 that were auto-generated?	Yes. DMAS will conduct post payment review to determine if respite criteria was met if the provider billed for respite.
4	My initial paperwork was sent to KePRO on 07/11/13 for a new admission. The 30 day visit is due this week. Should we do the 30 day visit now, or wait & do it when we receive an authorization?	This response applies to new admissions for both consumer and agency directed. Providers are to follow all the rules as outlined in the manuals to decrease potential penalty on post payment review.

Methods of Submission to KePRO

All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media type, for service authorization requests submitted to KePRO. KePRO accepts service authorization (srv auth) requests through direct data entry (DDE), fax and phone.

Submitting through Direct Data Entry (DDE) places the request in the worker queue immediately. For DDE, providers must use Atrezzo Connect Provider Portal. For DDE, service authorization checklists may be accessed on KePRO's website to assist in assuring specific information is included with each request. To access Atrezzo Connect on KePRO's website, go to http://dmas.kepro.com. Faxes are entered by staff in the order received

Provider registration is required to use Atrezzo Connect. The registration process for providers is immediate on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on "*Register*" to be prompted through the registration process. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. The Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, then the *General* tab.

Providers with questions about KePRO's Atrezzo Connect Provider Portal may contact KePRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KePRO at providerissues@kepro.com. KePRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

Methods of Submission to the Department of Behavioral Health and Developmental Services (DBHDS)

The Department of Behavioral Health and Developmental Services (DBHDS) receives electronic submissions of Individual Service Authorization Request through Intellectual Disability On-Line System (IDOLS). DBHDS manages the service authorization for all Intellectual Disability (ID) and Day Support Waiver Services. To access IDOLS all providers must have set up accounts in DBHDS' Delta system. Delta is DBHDS sign in solution and security portal which links to IDOLS. The provider agency's local administrator grants security access to the staff for applications in IDOLS, including service authorizations.

For additional information on service authorization and the IDOLS system at DBHDS, go to http://www.dbhds.virginia.gov/ODS-UsefulInformation.htm#mr4 under the Office of Developmental Services webpage listing, *IDOL Service Authorization Manual*.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only and have your Medicaid Provider Identification Number available when you call.